GROUP SMART CASH – MICRO INSURANCE

PROSPECTUS

Introduction

Group Smart Cash – Micro Insurance will provide a fixed amount for each day of hospitalisation, irrespective of the medical costs. This policy will help to cover the incidental and ancillary expenses (medical and non-medical) that are not covered under the basic health insurance policy.

Key Features & Benefits

- Hospital Daily Cash Benefit
- Accident Daily Cash Benefit
- ICU Daily Cash Benefit
- Alternative Treatment Benefit (optional benefit)

1. BASE COVERS

The Benefits available under this Policy are described below. Benefits will be payable subject to the terms, conditions and exclusions of this Policy and subject to Deductible/ Franchise, if any and specified in respect of that Benefit and any limits applicable for the Insured Person as specified in the Policy Schedule/ Certificate of Insurance.

1.1 Hospital Daily Cash Benefit

We will pay the Daily Cash Amount, subject to Deductible/ Franchise, as specified in the Policy Schedule/ Certificate of Insurance under this Benefit for each and every completed day of the Insured Person's Hospitalisation for Inpatient Care including AYUSH treatment during this Policy Period.

We shall be liable to make payment only for the maximum number of days per policy year per Insured Person/ per family as specified in the Policy Schedule/Certificate of Insurance for this Cover.

In case of Individual Policy, the maximum number of days will be on individual basis and in case of Floater Policy the maximum number of days will be on floater basis.

1.2 Accident Daily Cash Benefit

We will pay the Daily Cash Amount, subject to Deductible/ Franchise, as specified in the Policy Schedule/ Certificate of Insurance under this Benefit for each and every completed day of the Insured Person's Hospitalisation for Inpatient Care including AYUSH treatment during this Policy Period provided that:

(a) The Hospitalisation is following an Injury due to an Accident during this Policy Period

We shall be liable to make payment only for the maximum number of days per policy year per Insured Person/ per family as specified in the Policy Schedule/Certificate of Insurance for this Cover.

In case of Individual Policy, the maximum number of days will be on individual basis and in case of Floater Policy the maximum number of days will be on floater basis.

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1.3 ICU Daily Cash Benefit

We will pay the Daily Cash Amount, subject to Deductible/ Franchise, specified in the Policy Schedule/ Certificate of Insurance under this Benefit for each and every completed day of the Insured Person's Hospitalisation for Inpatient Care including AYUSH treatment in an ICU during this Policy Period.

If only Base Cover 1.2 Accident Daily Cash Benefit is opted for along with this cover, payout under this benefit will be restricted to Hospitalisation in an ICU following an Injury due to an Accident.

We shall be liable to make payment only for the maximum number of days per policy year per Insured Person/ per family as specified in the Policy Schedule/Certificate of Insurance for this Cover.

In case of Individual Policy, the maximum number of days will be on individual basis and in case of Floater Policy the maximum number of days will be on floater basis.

You can opt for any one of the Base Covers or a combination of 2 Base Covers or all 3 Base Covers.

2. OPTIONAL COVERS

The following covers are available under the Policy only if We have received the applicable premium due for that cover in full and the Policy Schedule/ Certificate of Insurance specifies that the cover is in force for the Insured Person.

The Optional covers available are described below. Benefit / reimbursement under the section will be payable as per the amount/Sum Insured shown in the Policy Schedule / Certificate of Insurance, subject to

- An event or occurrence described in such covers that occurs during the Policy Period.
- Availability of Daily Cash Amount and any limits applicable under the Product/ Covers in force for the Insured Person.
- The terms, conditions and exclusions of this Policy.

2.1 Convalescence Benefit

We will pay the Sum Insured specified in the Policy Schedule/Certificate of Insurance for this Benefit if the Insured Person is admitted in a Hospital for a minimum period as specified in the Policy Schedule/ Certificate of Insurance provided that:

(a) We have accepted a Claim for the Base Cover under the Policy in respect of the same Hospitalisation;
(b) We shall be liable to make payment under this cover in respect of an Insured Person only once during the Policy Year.
(c) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

The payment under this benefit is over and above the Base Cover, subject to limits specified, if any.

2.2 Companion Benefit

We will pay the Daily Cash Amount, specified in the Policy Schedule/ Certificate of Insurance under this Benefit towards expenses incurred on one accompanying person at the Hospital/Nursing Home for each and every completed day of the Insured Person's Hospitalisation during this Policy Period provided that:

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(a) We have accepted a Claim for the Base Cover under the Policy in respect of the same Hospitalisation;
(b) In case of Individual Policy, the maximum number of days will be on individual basis and in case of Floater Policy the maximum number of days will be on floater basis.

We shall be liable to make payment only for the maximum number of days per policy year per Insured Person/ per family as specified in the Policy Schedule/Certificate of Insurance for this Cover.

Companion will include "Your spouse, children, siblings and parent(s)"

The payment under this benefit is over and above the Base Cover, subject to limits specified, if any.

2.3 Joint Hospitalisation

We will pay the Sum Insured specified in the Policy Schedule/ Certificate of Insurance under this Benefit if two or more Insured Persons (Insured Person and his Family members) under the same Policy are jointly hospitalized as an inpatient during the Policy Period provided that:

(a) We have accepted a Claim for the Base Cover under the Policy in respect of the same Hospitalisation for any one Insured Person;
(b) This benefit is payable on lump sum basis irrespective of number of insured persons jointly hospitalized under this Policy (individual/floater)

We shall be liable to make payment under this cover only once during the Policy Year.

The payment under this benefit is over and above the Base Cover, subject to limits specified, if any.

2.4 Parent Accommodation

We will pay the Daily Cash Amount towards accommodation of parents of the Insured Person specified in the Policy Schedule for this Benefit for each and every completed day of the Insured Person's Hospitalization during this Policy Period provided that:

(a) We have accepted a Claim for the Base Cover under the Policy in respect of the same Hospitalisation;
(b) The Insured Person hospitalized is a Child aged 12 years or below
(c) In case of Individual Policy, the maximum number of days will be on individual basis and in case of Floater Policy the maximum number of days will be on floater basis.

We shall be liable to make payment only for the maximum number of days per policy year per Insured Person/per family as specified in the Policy Schedule/Certificate of Insurance for this Cover.

The payment under this benefit is over and above the Base Cover, subject to limits specified, if any.

2.5 Day Care Procedure Benefit

We will pay the Sum Insured specified in the of Policy Schedule/Certificate Insurance for this Benefit if an Insured Person undergoes a Day Care Procedure as an inpatient for less than 24 hours in a Hospital or Day Care Centre during the Policy Period.

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We will only pay for this Benefit for those Day Care Treatments which are listed in Annexure II of this Policy. The complete list of Day Care Treatments covered is also available on Our website [www.zurichkotak.com]

We shall be liable to make payment under this cover in respect of an Insured Person only once during the Policy Year.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

The payment under this benefit is over and above the Base Cover, subject to limits specified, if any.

2.6 Surgery Benefit

We will pay the Sum Insured specified in the Policy Schedule/ Certificate of Insurance, for this Benefit in the event of Insured Person's Hospitalisation for Inpatient Care during the Policy Period if an Insured Person undergoes a Surgery/ Surgical Procedure.

We shall be liable to make payment under this cover in respect of an Insured Person only once during the Policy Year.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

The payment under the Surgery Benefit is payable in respect of those surgeries/ treatments which are not listed under Day Care Treatments in Annexure II of this Policy.

The payment under this benefit is over and above the Base Cover, subject to limits specified, if any.

2.7 Accidental Hospitalisation Benefit

If an Insured Person suffers an Injury due to an Accident during the Policy Period that requires Inpatient Hospitalisation then, We shall reimburse the amount up to the limit specified against this benefit in the Policy Schedule / Certificate of Insurance, towards the Medical Expenses incurred in respect of a medical treatment or Surgery for the Injury sustained, provided that:

(a) The Hospitalisation is for a minimum and continuous period of 24 hours
(b) the Hospitalisation is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;
(c) the Medical Expenses incurred are Reasonable and Customary Charges;
(d) All non-medical expenses listed in Annexure III (List I) of the Policy will be payable as mentioned in the list.

The payment under this benefit is over and above the Base Cover, subject to limits specified, if any.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

2.8 Broken Bones

We will pay the amount as per percentage mentioned below in table of the Sum Insured as specified in the Policy Schedule / Certificate of Insurance if an Insured Person sustains Broken Bones directly due to

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an Accident that occurs during this Policy Period and which results in conditions specified in the table below:

Sr. No.	Particulars	Percentage of Sum Insured payable
1	Fractures of the Skull:	
	a) Compound fracture with damage to the brain tissue	100%
	b) Compound fracture without damage to the brain tissue	75%
	c) All other fractures	50%
2	Fractures of hip or pelvis (excluding thigh or coccyx):	
	a) Multiple fractures (at least one compound & one complete)	100%
	b) All other compound fractures	50%
	c) Multiple fractures, at least one complete	30%
	d) All other fractures	20%
3	Fracture of thigh or heel:	
	a) Multiple fractures (at least one compound & one complete)	50%
	b) All other compound fractures	40%
	c) Multiple fractures, at least one complete	30%
	d) All other fractures	20%
4	Fracture of Lower Leg, Clavicle, Ankle, Elbow, Upper or Lower Arm (including wrist, but excluding Colles-type fracture):	
	a) Multiple fractures (at least one compound & one complete)	40%
	b) All other compound fractures	30%
	c) Multiple fractures, at least one complete	20%
	d) All other fractures	12%
5	Fractures of Lower Jaw:	
	a) Multiple fractures (at least one compound & one complete)	30%
	b) All other compound fractures	20%
	c) Multiple fractures, at least one complete	16%
	d) All other fractures	8%
6	Fractures of Shoulder Blade, Kneecap, Sternum, Hand (excluding fingers and wrist), Foot (excluding toes and heel):	
	a) All compound fractures	20%
	b) All other fractures	10%
7	Colles type fracture to the Lower Arm:	
	a) Compound	20%
	b) Other	10%
8	Fractures of Spinal Column (Vertebrae but excluding coccyx):	
	a) All compression fractures	50%
	b) All spinous, transverse process or pedicle fractures	30%
	c) All other vertebral fractures	20%
9	Fractures of Rib or Ribs, Cheekbone, Coccyx, Upper Jaw, Nose, Toe and toes, finger or fingers:	
	a) Multiple fractures (at least one compound & one complete)	16%
	b) All other compound fractures	12%
	c) Multiple fractures, at least one complete	8%
	d) All other fractures	4%

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The Benefit specified above will be payable provided that:

(a) Any Fracture which results due to any Illness or disease (including malignancy) or due to osteoporosis shall not be payable under this benefit;
(b) If an Insured Person suffers a Fracture not specified in the table above but the Fracture is due to an Injury that is suffered during the Policy Period solely and directly due to an Accident that occurs during the Policy Period, then Our medical advisors will determine the amount payable, if any
(c) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Maximum amount payable in respect of multiple nature of fracture (more than 100%) would be restricted to Sum Insured opted by the Insured for this Benefit as mentioned in the Policy Schedule / Certificate of Insurance during the Policy Year.

2.9 Burns

We will pay the amount specified in the table below to the Insured Person up to the limit specified in the Policy Schedule / Certificate of Insurance if an Insured Person sustains burns directly due to an Accident that occurs during the Policy Period which results in conditions specified in the table below, provided that:
(a) The burns are not self-inflicted by the Insured Person in any way; and
(b) A Medical Practitioner has confirmed the diagnosis of the burn and the percentage of the surface area of the burn to Us in writing.
(c) If the bodily injury results in more than one of the nature of burns specified below, We shall be liable to pay for only the highest benefit among all.
(d) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Maximum amount payable in respect of multiple nature of disablement (more than 100%) would be restricted to Sum Insured opted by the Insured for this Benefit as mentioned in the Policy Schedule / Certificate of Insurance during the Policy Year.

Nature of Burns	**Percentage of Sum Insured payable**
1. Head	
a. Third degree burns of 8% or more of the total head surface area	100%
b. Second degree burns of 8% or more of the total head surface area	50%
c. Third degree burns of 5% or more, but less than 8% of the total head surface area	80%
d. Second degree burns of 5% or more, but less than 8% of the total head surface area	40%
e. Third degree burns of 2% or more, but less than 5% of the total head surface area	60%
f. Second degree burns of 2% or more, but less than 5% of the total head surface area	30%
2. **Rest of the body**	
a. Third degree burns of 20% or more of the total body surface area	100%
b. Second degree burns of 20% or more of the total body surface area	50%
c. Third degree burns of 15% or more, but less than 20% of the total body surface area	80%
d. Second degree burns of 15% or more, but less than 20% of the total body surface area	40%

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e. Third degree burns of 10% or more, but less than 15% of the total body surface area	60%
f. Second degree burns of 10% or more, but less than 15% of the total body surface area	30%
g. Third degree burns of 5% or more, but less than 10% of the total body surface area	20%
h. Second degree burns of 5% or more, but less than 10% of the total body surface area	10%

2.10 Maternity Benefit

We will pay the Daily Cash Amount, specified in the Policy Schedule/ Certificate of Insurance under the Maternity Benefit for the delivery of the Insured Person's child (including cesarean section) or for the Medically necessary and lawful termination of pregnancy for each and every completed day of the Insured Person's Hospitalisation during this Policy Period subject to the following:

(a) The treatment is taken as an In-patient in a Hospital
(b) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Permanent Exclusion 4.5(o) of the Policy Wordings stands deleted to the extent of this Benefit only.

2.11 New Born Baby Benefit

We will pay the Daily Cash Amount, specified in the Policy Schedule/ Certificate of Insurance under the New Born Baby Benefit for each and every completed day of the Hospitalisation of the Insured Person's New Born Baby during this Policy Period subject to the following:

(a) The treatment is taken as an In-patient in a Hospital
(b) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

You can cover the New Born Baby beyond 90 days on payment of requisite premium for the New Born Baby by way of an endorsement or at the next Renewal, whichever is earlier.

2.12 Worldwide Cover

We will pay the Daily Cash Amount, subject to Deductible/ Franchise, as specified in the Policy Schedule/ Certificate of Insurance under this Benefit for each and every completed day of the Insured Person's Hospitalisation during this Policy Period outside India subject to the following:

(a) The Insured Person undergoes Medically Necessary treatment of an Illness or an Injury
(b) In case of Individual Policy, the maximum number of days will be on individual basis and in case of Floater Policy the maximum number of days will be on floater basis.

We shall be liable to make payment only for the maximum number of days per policy year per Insured Person/per family as specified in the Policy Schedule/Certificate of Insurance for this Cover.

Permanent Exclusion 4.5(aa) of the Policy Wordings stands deleted to the extent of this Benefit only.

2.13 Personal Accident Benefit

We will pay Sum Insured upto the limit specified in the Policy Schedule for the covers mentioned herein, subject to the following:

(a) We shall be liable to make payment under this Cover only once in respect of any Insured Person across all Policy Periods;
(b) This cover is applicable on an individual basis irrespective of type of policy (Individual/ Floater)
(c) Notwithstanding any provision to the contrary in the Policy, this Cover will be applicable on a worldwide basis;

2.13.1 Accidental Death

We will pay the Sum Insured upto the limit specified in the Policy Schedule if the Insured Person dies solely and directly due to an Injury sustained in an Accident which occurs during the Policy Period, provided that the Insured Person's death occurs within 12 months from the date of that Accident.

Once a Claim has been accepted and paid under this Benefit then this Policy will automatically terminate in respect of that Insured Person only.

2.13.2 Permanent Total Disablement (PTD)

We will pay the Sum Insured upto the limit specified in the Policy Schedule if the Insured Person suffers Permanent Total Disablement of the nature specified below solely and directly due to an Accident which occurs during the Policy Period provided that the Permanent Total Disablement occurs within 12 months from the date of that Accident:

- Loss of Use of both eyes, or Physical Separation/ Loss of Use of two entire hands or two entire feet, or one entire hand and one entire foot, or of such Loss of Use of one eye and such Physical Separation/ Loss of Use of one entire hand or one entire foot.
- Physical Separation/ Loss of Use of two hands or two feet, or of one hand and one foot, or of Loss of Use of one eye and Loss of Use of one hand or one foot.
- If such Injury shall as a direct consequence thereof, permanently, and totally, disable the Insured Person from engaging in any employment or occupation of any description whatsoever.

Once a Claim has been accepted and paid under this Benefit then the Personal Accident Cover will automatically terminate in respect of that Insured Person only.

We shall not be liable to make any payment under of this Benefit directly or indirectly for, caused by, based upon, arising out of or howsoever attributable to any of the exclusions listed below:
(i) Disease, Injury, death or disablement directly or indirectly due to war, whether declared or not, or any warlike activities, including use of military force by any sovereign nation to achieve economic, geographic, nationalistic, political, racial, religious or other end's invasion, act of foreign enemy hostilities or civil commotion or rebellion, military, naval or air service or breach of law, hunting, steeple chasing, revolution, insurrection, mutiny.
(ii) Any Injury present prior to the commencement of Policy Period, whether or not if the same has been treated, or for which Medical Advice, diagnosis, care or treatment has been sought before the commencement of this Policy. Any Illness, complication or ailment arising out of or connected to such Injury.
(iii) Payment of compensation in respect of death, disablement (whether of a permanent nature or of a

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temporary nature), Injury, disease, Illness, Hospitalisation of Insured Person

(a) from intentional self-injury, suicide or attempted suicide;

(b) whilst under the influence of intoxicating liquor or drugs;

(c) whilst engaging in aviation or ballooning, or whilst mounting into, or dismounting from or traveling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any Scheduled Airlines in the world, or engaging in any kind of adventure sports for personal gratification.

[Standard type of aircraft means any aircraft duly licensed to carry passengers (for hire or otherwise) by appropriate authority irrespective of whether such an aircraft is privately owned or chartered or operated by a Scheduled Airline or whether such an aircraft has a single engine or multiengine;]

(d) directly or indirectly caused by venereal disease

(e) arising or resulting from the Insured Person committing any breach of law

(iv) Payment of compensation in respect of death, disablement (whether of a permanent nature or of a temporary nature), of Insured Person from participation in winter sports, skydiving/parachuting, hang gliding, bungee jumping, scuba diving, mountain climbing (where ropes or guides are customarily used), riding or driving in races or rallies using a motorized vehicle or bicycle, caving or pot-holing, hunting or equestrian activities, skin diving or other underwater activity, rafting or canoeing involving white water rapids, yachting or boating outside coastal waters (2 miles), participation in any Professional Sports, any bodily contact sport or any other hazardous or potentially dangerous sport for which the Insured Person is untrained, unless specifically covered under the Policy.

(v) Arising from ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel. For the purpose of this exclusion, combustion shall include any self-sustaining process of nuclear fission or nuclear fusion.

(vi) Nuclear weapon materials.

(vii) Death, disablement (whether of a permanent nature or of a temporary nature), Injury, disease, Illness, Hospitalisation of Insured Person resulting directly or indirectly arising out of, contributed to or caused by, or resulting from or in connection with any act of Nuclear, Chemical, Biological Terrorism (as defined below) regardless of any other cause or event contributing concurrently or in any other sequence to the loss.

(a) For the purpose of this exclusion "Nuclear, Chemical, Biological Terrorism" shall mean the use of any nuclear weapon or device or the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous Chemical agent and/or Biological agent (as defined hereunder) during the period of this insurance by any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious or ideological purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear.

(b) "Chemical" agent shall mean any compound, which, when suitably disseminated, produces incapacitating, damaging or lethal effects on people, animals, plants, or material property.

(c) "Biological" agent shall mean any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which cause Illness and/or death in humans, animals or plants.

The aforementioned exclusions are over and above the Permanent Exclusions 4.4 applicable to this cover 2.13

2.14 Critical Illness Benefit

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If the Insured Person is first diagnosed to be suffering from any of the following Critical Illnesses during the Policy Period, We will pay Sum Insured upto the limit specified in the Policy Schedule for this Cover, subject to the following:

(a) We shall not be liable to accept any Claim under this Cover if it pertains to any Critical Illness diagnosed within 90 days of the commencement of the first Policy Period of this Cover with Us;
(b) We shall not be liable to make payment under this Cover for more than once in respect of any Insured Person across all Policy Periods;

Further,

(a) This cover is applicable on an individual basis irrespective of type of policy (Individual/ Floater) and available for Insured Persons aged 18 years or above.
(b) Once a Claim has been accepted and paid for any of the listed Critical Illness, this benefit shall cease in respect of that Insured Person, but shall continue to be in force for other Insured Persons.
(c) Notwithstanding any provision to the contrary in the Policy, this Cover will be applicable on a worldwide basis;
(d) In the event of a Claim arising under this Cover, We shall be given written notice of the Claim within 30 days from the date of the first diagnosis of the Critical Illness and We shall be provided the following information and documentation:
    (i) The Claim documents stated in the Policy, provided that We will accept duly certified copies of the listed documents if the originals are required to be submitted to any other insurance company;
    (ii) Written confirmation of the diagnosis of the Critical Illness from the treating Medical Practitioner;

"Critical Illness" for the purpose of this Cover is as mentioned below:

- First diagnosis of the below-mentioned Illnesses more specifically described below
    1. Cancer of specified severity
    2. Kidney failure requiring regular dialysis;
    3. Multiple Sclerosis with persisting symptoms;
    4. Motor Neurone Disease with Permanent Symptoms
    5. Benign Brain Tumor
    6. Primary (Idiopathic) Pulmonary Hypertension
    7. End Stage Liver Failure
- Undergoing for the first time of the following surgical procedures, more specifically described below:
    8. Major Organ / Bone Marrow Transplant;
    9. Open heart replacement or repair of heart valves
    10. Open chest CABG
    11. Aorta Graft Surgery
- Occurrence for the first time of the following medical events more specifically described below:
    12. Coma of Specified Severity
    13. Stroke resulting in permanent symptoms;
    14. Permanent Paralysis of Limbs;
    15. Myocardial Infarction (First Heart Attack of specific severity.)
    16. Third Degree Burns
    17. Deafness
    18. Loss of Speech

The Critical Illnesses and the conditions applicable to the same are more particularly described in Annexure IV.

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2.15 Pre-existing Disease Waiting Period Waiver

Any claim arising out of, relating to or howsoever attributable to pre-existing diseases or any complication arising from the same will be covered from inception of the Policy or as per specifically opted waiting period as stated in the Policy Schedule/ Certificate of Insurance in which case the coverage will be applicable post the continuous coverage with Us

Exclusion No. 4.1 will not be applicable.

2.16 30 days Waiting Period Waiver

This benefit provides for waiver of Exclusion No. 4.2 of the Policy and the coverage under the Policy will commence from day one of the Policy period without any waiting period.

2.17 Specified disease/ procedure Waiting Period Waiver

This benefit provides for waiver of Exclusion No. 4.3 of the Policy and treatment in respect of diseases, illness, and injury as mentioned in Exclusion No. 4.3 of this Policy shall stand covered from day one of the Policy period without any waiting period.

2.18 Maternity Benefit Waiting Period Waiver

This benefit provides for waiver of Exclusion No. 4.4 of the Policy in respect of Maternity Benefit claims, and coverage under the Policy for Maternity claims will commence from day one of the Policy period.
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3. SPECIAL CONDITIONS APPLICABLE FOR CLAIMS

3.1 Deductible/ Franchise

In case the Policy covers Hospital Daily Cash Benefit, ICU Daily Cash Benefit and Accident Daily Cash Benefit, the Deductible/ Franchise will be applied only once on the entire duration of the stay in the hospital.

Illustration:

Scenario 1:
Maximum number of days: 30. The Insured Person stays in the Hospital for 10 days and Policy Deductible is 3 days. Out of the 10 days, first 4 days is Normal Room and remaining 6 days is ICU.

The Deductible will be applied for the first 3 days. The Insured will get the Hospital Daily Cash Benefit for the 4th day and for the remaining 6 days, he will get the ICU Daily Cash Benefit.

Scenario 2:
Maximum number of days: 30. The Insured Person stays in the Hospital for 10 days and Policy Deductible is 3 days. Out of the 10 days, first 4 days is ICU and remaining 6 days is Normal Room.

The Deductible will be applied for the first 3 days. The Insured will get the ICU Daily Cash Benefit for the 4th day and for the remaining 6 days, he will get the Hospital Daily Cash Benefit.

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Scenario 3:
Maximum number of days: 30. The Insured Person stays in the Hospital for 10 days and Policy Franchise is 3 days. Out of the 10 days, first 4 days is ICU and remaining 6 days is Normal Room.

As the Franchise limit of first 3 days is crossed, the Insured will get the ICU Daily Cash Benefit for 4 days and for the remaining 6 days, he will get the Hospital Daily Cash Benefit.

3.2 Maximum Payout

In case the Insured Person's Hospitalisation covers Hospital Daily Cash Benefit or ICU Daily Cash Benefit or Accident Daily Cash Benefit or combination of these, the highest of the Daily Cash Amount applicable will be paid in respect of each and every completed day depending on the type of Hospitalisation (Illness/ ICU/ Accident). There will be no cumulative payout under these 3 Benefits and only the highest of the payout applicable will be paid.

Illustration:

Scenario 1:
Maximum number of days: 30
Hospital Daily Cash Benefit – Rs. 1000 per day
ICU Daily Cash Benefit – Rs. 2000 per day
Policy Deductible – 1 day

The Insured Person gets hospitalised and stays in the Hospital for 10 days. Out of the 10 days, first 4 days is Normal Room and remaining 6 days is ICU.

In this case, the payout will be as follows:

	Total number of days	Total Payout
Hospital Daily Cash Benefit (after one day Deductible)	3 days	3 * 1000 per day = Rs. 3000
ICU Daily Cash Benefit (*)	6 days	6 * 2000 per day = Rs. 12000

Payable amount – Rs. 15000/-

(*) The Insured is eligible for the higher payout of ICU Benefit in this scenario.

Scenario 2:
Maximum number of days: 30
Hospital Daily Cash Benefit – Rs. 1000 per day
Accident Daily Cash Benefit – Rs. 2000 per day
Policy Deductible – 1 day

The Insured Person gets hospitalised due to Accident and stays in the Hospital in a Normal Room for 10 days.

In this case, the payout will be as follows:

	Total number of days	Total Payout
Accident Daily Cash Benefit (after one day Deductible)	9 days	9 * 2000 per day = Rs. 18000

Payable amount – Rs. 18000/-

As the Accident Daily Cash Payout is higher, only the higher payout is made in the above scenario.

Scenario 3:
Maximum number of days: 30
Hospital Daily Cash Benefit – Rs. 1000 per day
Accident Daily Cash Benefit – Rs. 2000 per day
ICU Daily Cash Benefit – Rs. 3000 per day
Policy Deductible – 1 day

The Insured Person gets hospitalised due to Accident and stays in the Hospital in a Normal Room for first 4 days and ICU for next 6 days.

In this case, the payout will be as follows:

	Total number of days	Total Payout
Accident Daily Cash Benefit (after one day Deductible)	3 days	3 * 2000 per day = Rs. 6000
ICU Daily Cash Benefit	6 days	6* 3000 per day = Rs. 18000

Payable amount – Rs. 24000/-

As the Accident Daily Cash Payout is higher, only the higher payout is made in the above scenario for first 4 days. ICU Daily Cash Benefit is also provided for the remaining 6 days

3.3 Maximum Coverage Limit

- The maximum number of days coverage will be as mentioned in the Policy Schedule/ Certificate of Insurance per Insured Person/ per family. If all claims in a Policy Year do not meet the Maximum Coverage Limit, then it is agreed and understood that there will be no carry-over of days to the subsequent Policy Year or any future renewals of the Policy.

- In case the Policy covers Hospital Daily Cash Benefit or ICU Daily Cash Benefit or Accident Daily Cash Benefit or combination of these, the maximum number of days under each Benefit will be considered individually as mentioned in the Policy Schedule/ Certificate of Insurance.

Illustration:

Maximum number of days for Hospital Daily Cash: 30 days
Maximum number of days for ICU Daily Cash: 15 days
Hospital Daily Cash Benefit – Rs. 1000 per day
ICU Daily Cash Benefit – Rs. 2000 per day
Policy Deductible – 1 day

The Insured Person gets hospitalised and stays in the Hospital for 50 days. Out of the 50 days, first 20 days is in ICU and remaining 30 days is Normal Room.

In this case, the payout will be as follows:

	Total number of days	Total Payout
ICU Daily Cash Benefit (after one day Deductible)	15 days	15 * 2000 per day = Rs. 30000
Hospital Daily Cash Benefit (*)	29 days	29 * 1000 per day = Rs. 29000

Payable amount – Rs. 59000/-

(*) The Insured is eligible for the Hospital Daily Cash payout in this scenario from the 16th day although the Insured is in ICU as the 15 days of ICU Benefit have been utilised. From the 16th day, Insured will get a Hospital Daily Cash Benefit upto the maximum number of days opted.

4. WHAT WE WILL NOT PAY (EXCLUSIONS APPLICABLE UNDER THE POLICY)

4.1 Pre-Existing Diseases (Code – Excl01)

(a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.
(b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
(c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
(d) Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

4.2 30 Days Waiting Period (Code – Excl03)

(a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
(b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
(c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4.3 Specified disease/ procedure waiting period (Code – Excl02)

(a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
(b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

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(c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
(d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
(e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
(f) List of specific diseases/procedures
  (a) Cataract;
  (b) Benign Prostatic Hypertrophy;
  (c) Myomectomy, Hysterectomy unless because of malignancy;
  (d) All types of Hernia, Hydrocele;
  (e) Fissures and/or Fistula in anus, haemorrhoids/piles;
  (f) Arthritis, gout, rheumatism and spinal disorders;
  (g) Joint replacements unless due to Accident;
  (h) Sinusitis and related disorders;
  (i) Stones in the urinary and biliary systems;
  (j) Dilatation and curettage, Endometriosis;
  (k) All types of skin and internal tumors/ cysts/ nodules/ polyps of any kind including breast lumps unless malignant;
  (l) Dialysis required for chronic renal failure;
  (m) Tonsillitis, adenoids and sinuses;
  (n) Gastric and duodenal erosions and ulcers;
  (o) Deviated nasal septum;
  (p) Varicose Veins/ Varicose Ulcers.

4.4 Maternity Benefit Waiting Period

Maternity Benefit will not be applicable during the first 9 months from the Policy Period Start Date. This exclusion does not apply to Renewals of the Policy with Us or to any Insured Person whose Policy has been accepted under the Portability Benefit under this Policy

4.5 Permanent Exclusions

(a) Investigation & Evaluation (Code- Excl04)

a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded

(b) Rest Cure, rehabilitation and respite care (Code – Excl05)

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
  i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
  ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

(c) Obesity/ Weight Control (Code – Excl06)

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
   a) greater than or equal to 40 or
   b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

(d) Change-of- Gender treatments (Code – Excl07)

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

(e) Cosmetic or plastic Surgery (Code – Excl08)

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

(f) Hazardous or Adventure sports: (Code- Excl09)

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

(g) Breach of law (Code – Excl10)

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

(h) Excluded Providers: (Code- Excl11)

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

(i) Code- Excl12

Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof

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(j) Code- Excl13

Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.

(k) Code- Excl14

Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure.

(l) Refractive Error (Code- Excl15)

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

(m) Unproven Treatments (Code – Excl16)

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

(n) Sterility and Infertility (Code- Excl17)

Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization
ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy
iv. Reversal of sterilization

(o) **Maternity (Code- Excl18)**

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

(p) Costs of routine medical, eye or ear examinations preventive health check-ups, spectacles, laser surgery for correction of refractory errors, contact lenses, hearing aids, dentures or artificial teeth;

(q) Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, crutches, instruments used in treatment of sleep apnoea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively;

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(r) Expenses incurred on all dental treatment unless necessitated due to an Accident and treated as an in-patient;

(s) Any expenses incurred on personal comfort, cosmetics, convenience and hygiene related items and services;

(t) Any acupressure, acupuncture, magnetic and such other therapies;

(u) Circumcision unless necessary for treatment of an Illness or necessitated due to an Accident;

(v) Vaccination or inoculation of any kind, unless it is post animal bite and treated as an in-patient;

(w) Intentional self-injury (whether arising from an attempt to commit suicide or otherwise);

(x) Treatment relating to Congenital external Anomalies;

(y) any treatment related to sleep disorder or sleep apnoea syndrome, general debility, convalescence, run-down condition or rest cures;

(z) Costs incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose;

(aa) Any treatment taken outside India;

(bb) Any treatment taken from anyone not falling within the scope of definition of Medical Practitioner. Any treatment charges or fees charged by any Medical Practitioner acting outside the scope of licence or registration granted to him by any medical council;

(cc) Non- allopathic Treatment other than AYUSH treatment

(dd) Domiciliary Hospitalisation

(ee) Any consequential or indirect loss arising out of or related to Hospitalization;

(ff) Any Injury or Illness directly or indirectly caused by or arising from or attributable to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority;

(gg) Any Illness or Injury directly or indirectly caused by or contributed to by nuclear weapons/materials or contributed to by or arising from ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel;

(hh) Any OPD treatment will not be covered

(ii) Medical supplies including elastic stockings, diabetic test strips, and similar products.

(jj) Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.

(kk) External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy will not be covered unless it forms a part of in-patient treatment in case of hospitalisation or part of discharge advice upto the Post hospitalisation period as specified in the policy Schedule/ Certificate of Insurance.

(ll) Any physical, medical condition or treatment that is specifically excluded in the Policy Schedule under Important Conditions

5. CLAIMS PROCESS

5.1 Claim Administration

The fulfilment of the terms and conditions of this Policy (including payment of premium by the due dates mentioned in the Policy Schedule/ Certificate of Insurance) insofar as they relate to anything to be done or complied with by You or any Insured Person, including complying with the following in relation to claims, shall be Condition Precedent to admission of Our liability under this Policy:

a) On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed;
b) If requested by Us and at Our cost, We may conduct Medical examination by any Medical Practitioner for this purpose when and so often as We may reasonably require. Such medical examination will be carried out only in case of reimbursement claims with prior consent of the Insured Person and We/Our representatives must be permitted to inspect the medical and Hospitalisation records pertaining to the Insured Person's treatment and to investigate the facts surrounding the Claim;
c) We/Our representatives must be given all reasonable co-operation in investigating the Claim in order to assess Our liability and quantum in respect of such Claim;
d) If the Insured Person suffers a relapse within 45 days of the date of discharge from Hospital for a Claim that has been made, then such relapse shall be deemed to be part of the same Claim and all limits for Any One Illness under this Policy shall be applied as if they were part of a single claim.

5.2 Claims Intimation

In the event of a Hospitalization claim under the Policy, We must be notified either at Our call centre or in writing within 48 hours of the Hospitalization but not later than discharge from the Hospital. In case of an Accidental Death or Permanent Total Disablement/ Critical Illness claim under Benefit 2.14 and 2.15 of the Policy, We must be notified either at Our call centre or in writing within 10 days from the date of occurrence of the Accident.

We shall be provided the following necessary information and documentation in respect of the Claims is within 30 days of the Insured Person's occurred Injury/ Hospitalisation:

(a) Policy Number
(b) Name of the Policyholder

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(c) Name of the Insured Person in whose relation the Claim is being lodged
(d) Nature of Accident (if Accident Case)
(e) Name and address of the attending Medical Practitioner and Hospital (if Admission has taken place)
(f) Date of Admission if applicable
(g) Any other information, documentation as requested by Us

In Case of Claim Contact Us at:
24x7 Toll Free number: 1800 266 4545 or may write an e- mail at care@zurichkotak.com

In the event of claims, please send the relevant documents to:
Claims Manager

Zurich Kotak General Insurance Company (India) Limited
401, 4th Floor, Silver Metropolis, Jai Coach Compound,
Off Western Express Highway,
Goregaon (East), Mumbai- 400063.
Maharashtra, India.

If the Claim is not notified to Us within the time period specified above, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

5.3 Claims Documents

a) Basic documents required for all Claims:

(i) Applicable KYC documents along with latest photographs, Valid Photo ID, address proof, etc.
(ii) Duly completed and signed Claim form in original as prescribed by Us.

b) Benefit-wise Additional Documents:

Sr. No.	Name of the Cover	Documents
1.	Hospital Daily Cash Benefit	Hospital discharge card/ summary, copy of treatment papers, medical investigation reports and copy of hospital bill
2.	Accident Daily Cash Benefit	Hospital discharge card/ summary, copy of treatment papers, medical investigation reports and copy of hospital bill
3.	ICU Daily Cash Benefit	Hospital discharge card/ summary, copy of treatment papers, medical investigation reports and copy of hospital bill
4.	Convalescence Benefit	Hospital discharge card/ summary
5.	Companion Benefit	Hospital discharge card/ summary and document to confirm relationship with the Patient
6.	Joint Hospitalisation	Hospital discharge card/ summary of each Insured Person hospitalised

7.	Parent Accommodation	Copy of discharge card and document to confirm relationship with the Patient
8.	Day Care Procedure Benefit	Hospital discharge card/ summary, copy of treatment papers, medical investigation reports and copy of hospital bill
9.	Surgery Benefit	Hospital discharge card/ summary, copy of treatment papers, medical investigation reports and copy of hospital bill
10.	Accidental Hospitalisation Benefit	Medical investigation report, Original hospital bill & receipts and Treatment papers,, FIR (if done) or MLC (if conducted) for Accident cases
11.	Broken Bones	a. X-Ray/ MRI/ CT-Scan/ Radiology Films/ Reports confirming the extent of fracture, Copy of treatment papers
12.	Burns	Certificate from the treating doctor certifying the extent of burns injury, Copy of treatment papers

c) In case of Accidental Death:

(i) Original Death certificate issued by the office of Registrar of Birth & Deaths;
(ii) Death summary issued by a Hospital;
(iii) Post Mortem Report (if conducted);
(iv) Copies of Medical records (if available), investigation reports (if available), if admitted to hospital
(v) Identity proof of Nominee or Original Succession Certificate/Original Legal Heir Certificate or any other proof to the satisfaction of the Company for the purpose of a valid discharge in case nomination is not filed by deceased.

d) Documents required in case of Permanent Total Disablement

(i) Original treating Medical Practitioner's certificate describing the disablement;
(ii) Original Discharge summary from the Hospital;
(iii) Photograph of the Insured Person reflecting the disablement;
(iv) Prescriptions and consultation papers of the treatment; Disability certificate issued by civil surgeon or equivalent appointed by the District/State or Government Board.
(v) Copies of Medical records (if available), investigation reports (if available), if admitted to hospital.
(vi) Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable

e) Documents required in case of Critical Illness Claims

(i) Duly completed claim form;
(ii) Certificate from the attending Medical Practitioner of the Insured Person confirming, inter alia,
(iii) Name of the Insured Person;
(iv) Name, date of occurrence and medical details confirming the event giving rise to the Claim.
(v) Written confirmation from the treating Medical Practitioner that the event giving rise to the Claim does not relate to any Pre-Existing Disease or any Illness or Injury which

was diagnosed within the first 90 days of commencement of first Policy Period with Us.

(vi) Original Policy document;

(vii) Original Discharge Certificate/Death Summary/Card from the hospital/ Medical Practitioner;

(viii) Original investigation test reports, indoor case papers;

(ix) In the cases where Critical Illness arises due to an Accident, FIR copy or medico legal certificate (if done/conducted) will also be required wherever conducted. We may call for any additional necessary documents/information as required based on the circumstances of the claim.

(x) Any other documents as may be required by Us.

Specific Documentation Required for each of the Critical Illnesses

Please note that the following are illustrative lists and we may seek additional documentation based on the facts and circumstances of the Claim and if done/conducted/available

1) CANCER OF SPECIFIED SEVERITY
   i. Hospital Discharge Card photocopy
   ii. Hospital Bills photocopy
   iii. Photocopy of Pharmacy/Investigations Bills
   iv. Investigations Reports
   v. Details of the treatment received by the Insured Person from the inception of the ailment.
   vi. Letter from treating consultant stating presenting complaints with duration and the past medical history.
   vii. Histopathology / Cytology / FNAC / Biopsy / Immuno-histochemistry reports.
   viii. X-Ray / CT scan / MRI scan / USG / Radioisotope / Bone scan Reports.
   ix. Blood Tests.
   x. Any other specific investigation done to support the diagnosis like the Pap smear/ Mammography, etc.
   xi. Any other documents as may be required by Us.

2) KIDNEY FAILURE REQUIRING REGULAR DIALYSIS
   i. Hospital Discharge Card photocopy
   ii. Photocopy of Hospital Bills.
   iii. Photocopy of Pharmacy/Investigations Bills
   iv. Investigations Reports
   v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
   vi. Blood Tests- Renal Function Tests specifically: Serum Creatinine, Blood Urea Nitrogen, Serum Electrolytes done in the recent past (Not more than Two Week period from the date of intimation of Loss)
   vii. Dialysis Papers/Receipts done in recent past.
   viii. Renal scan
   ix. Letter from the nephrologists stating the diagnosis of End Stage Kidney Failure.
   x. Any other documents as may be required by Us.

3) MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS
   i. Hospital Discharge Card photocopy
   ii. Photocopy of Hospital Bills.
   iii. Photocopy of Pharmacy/Investigations Bills
   iv. Investigations Reports
   v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
   vi. MRI / CT Scan Report.
   vii. Electro-myogram report
   viii. Biopsy / Cytology Report
   ix. Specific Blood Tests: Creatinine Phosphokinase /Anti-nuclear antibodies, C- reactive protein /autoimmune work up
   x. Any other relevant Blood investigations.

xi. Confirmation from the Central/State Government Hospital about diagnosis of Multiple Sclerosis and the duration of the same.
xii. Any other documents as may be required by Us.

4) MOTOR NEURONE DISEASE WITH PERMANENT SYMPTOMS
i. Hospital Discharge Card photocopy (in case of Hospitalization)
ii. Investigations Reports like Blood tests, EEG, Nerve Conduction test, etc
iii. MRI / CT scan Reports or any other Imaging technique Used during the diagnosis and treatment
iv. Electro-myogram Report
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologist/ Physician stating the Neurological deficit and the degree/current status
vii. Any other document as may be required by the company

5) BENIGN BRAIN TUMOR
i. Hospital Discharge Card photocopy
ii. Hospital Bills photocopy
iii. Photocopy of Pharmacy/Investigations Bills
iv. Investigations Reports
v. Details of the treatment received by the Insured Person from the inception of the ailment.
vi. Letter from treating consultant stating presenting complaints with duration and the past medical history.
vii. Histopathology / Cytology / FNAC / Biopsy / Immuno-histochemistry reports.
viii. X-Ray / CT scan / MRI scan / USG / Radioisotope / Bone scan Reports.
ix. Blood Tests.
x. Neurological examination report by Neurologist
xi. Any other documents as may be required by Us.

6) PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION
i. Hospital Discharge Card photocopy
ii. Photocopy of Hospital Bills.
iii. Photocopy of Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. MRI / CT Scan Report.
vii. Echocardiography report
viii. Computed tomography (CT), magnetic resonance imaging (MRI), and lung scanning
ix. Pulmonary angiography
x. Any other documents as may be required by Us.

7) END STAGE LIVER FAILURE
i. Hospital Discharge Card photocopy
ii. Photocopy of Hospital Bills.
iii. Photocopy of Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.

vi. Ultrasound scan of liver
vii. CT and/or MRI scan of the liver
viii. X-ray and Liver function test
ix. Biopsy / FNAC (where applicable)
x. Any other documents as may be required by Us.

8) MAJOR ORGAN /BONE MARROW TRANSPLANT
i. Hospital Discharge Card photocopy
ii. Photocopy of Hospital Bills.
iii. Photocopy of Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Scan / Histopathology / Cytology / FNAC / Biopsy report suggesting irreversible & non-compensatory changes of the particular organ. 8 Bone Marrow Biopsy Reports (Specifically In Case of Bone Marrow Transplant)
vii. Letter from a specialist Doctor confirming the need of transplantation (Organs Specified are: Heart, lung, Liver, pancreas, kidney, bone marrow)
viii. Any other documents as may be required by Us.

9) OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES
i. Hospital Discharge Card photocopy
ii. Photocopy of Hospital Bills.
iii. Photocopy of Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. X-ray and 2D-Echocardiography Report.
vii. Letter from the Cardiologist / Cardiothoracic Surgeon suggesting valve replacement with the type of valve to be used.
viii. Any other documents as may be required by Us.

10) OPEN CHEST CABG
i. Photocopy of Hospital Discharge Card
ii. Photocopy of Hospital Bills.
iii. Photocopy of Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. ECG at the time of detection of Coronary Artery Disease and Subsequent ECG's
vii. Stress test/ Tread Mill Test
viii. Letter from treating consultant suggesting Coronary Angiography and CABG
ix. Coronary Angiography report / CT Angiography Report
x. Cardiac Enzymes Tests: Troponin T/Troponin I, CPK / CPK-MB, SGOT / SGPT,
xi. LDH / Electrolytes
xii. X-ray / 2D-Echocardiography Report
xiii. Thallium Scan Report
xiv. Any other documents as may be required by Us.

11) AORTA GRAFT SURGERY

i. Photocopy of Hospital Discharge Card
ii. Photocopy of Hospital Bills.
iii. Photocopy of Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. ECG at the time of detection of Coronary Artery Disease and Subsequent ECG's
vii. Stress test/ Tread Mill Test
viii. Letter from treating consultant suggesting Coronary Angiography and CABG
ix. Coronary Angiography report / CT Scan
x. Cardiac Enzymes Tests: Troponin T/Troponin I, CPK / CPK-MB, SGOT / SGPT,
xi. LDH / Electrolytes
xii. X-ray / 2D-Echocardiography Report
xiii. Thallium Scan Report
xiv. Bio-markers for Aortic dissection
xv. Any other documents as may be required by Us.

12) COMA OF SPECIFIED SEVERITY

i. Hospital Discharge Card photocopy
ii. Investigations Reports like Blood tests, EEG, etc
iii. MRI / CT scan Reports or any other Imaging technique Used during the diagnosis and treatment
iv. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologist/ Physician stating the Glasgow coma scale grading.
v. Indoor case papers and / or ICU case papers indicating the history, signs, symptoms, line of treatment and daily charts like TPR, etc
vi. FIR / MLC / Panchnama for accident induced coma
vii. Any other document as may be required by the company

13) STROKE RESULTING IN PERMANENT SYMPTOMS

i. Hospital Discharge Card photocopy
ii. Photocopy of Hospital Bills.
iii. Photocopy of Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologist/ Physician stating the Neurological deficit.
vii. MRI / CT scan/ 2D Echocardiography Reports or any other Imaging technique Used during the diagnosis and treatment of the Stroke
viii. Blood tests (Lipid profile/Random Blood Sugar / Prothrombin Time/APTT/ Bleeding Time/ Clotting Time/Homocystiene levels)
ix. Any other documents as may be required by Us.

14) PERMANENT PARALYSIS OF LIMBS

i. Hospital Discharge Card photocopy
ii. Investigations Reports
iii. MRI / CT scan Reports or any other Imaging technique Used during the diagnosis and treatment of the Stroke
iv. Electro-myogram Report
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologist/ Physician stating the Neurological deficit and the degree/current status and duration of the Paralysis.
vii. Any other document as may be required by the company

15) MYOCARDIAL INFARCTION - FIRST HEART ATTACK - OF SPECIFIC SEVERITY

i. Hospital Discharge Card photocopy
ii. Photocopy of Hospital Bills.
iii. Photocopy of Pharmacy/Investigations Bills
iv. Investigations Reports
v. Casualty Medical Officers/Emergency room papers with all details of Presenting Complaints and the Medical Examination by the attending physician.
vi. Subsequent Consultation Papers with the treating Medical Practitioner and the treatment received
vii. ECG on admission and subsequent ECG's
viii. Stress test/ Tread Mill Test
ix. Cardiac Enzymes Tests: Troponin T/Troponin I, CPK / CPK-MB, SGOT / SGPT, LDH / Electrolytes
x. X-ray / 2D-Echocardiography Report
xi. Thallium Scan Report
xii. Any other documents as may be required by Us.

16) THIRD DEGREE BURNS

i. Hospital Discharge Card photocopy
ii. Photocopy of Hospital Bills.
iii. Photocopy of Pharmacy/Investigations Bills
iv. Investigations Reports, treatment papers
v. Certificate from the treating specialist Doctor indicating the classification / degree of burns
vi. Following medico-legal documents if applicable
    (i) FIR
    (ii) Panchnama
    (iii) Inquest Panchnama
    (iv) Police Final Report/Charge Sheet (Based on FIR)
vii. Any other documents as may be required by Us.

17) DEAFNESS
i. Hospital Discharge Card photocopy
ii. Photocopy of Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Pure tone testing report
vii. Audiometry report
viii. Confirmation of Diagnosis by ENT specialist along with duration
ix. All treatment papers and medical investigation test reports
x. Any other documents as may be required by Us.

18) LOSS OF SPEECH
i. Hospital Discharge Card photocopy
ii. Photocopy of Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Confirmation of Diagnosis by ENT specialist along with cause and duration
vii. All treatment papers and medical investigation test reports
viii. Any other documents as may be required by Us.

Note:

If the original documents mentioned above are submitted to any other insurance company, self-attested copies along with certificate from that Insurance Company to be submitted under this Policy.

General Terms and Clauses

1. Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

2. Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

3. Complete Discharge

Zurich Kotak General Insurance Company (India) Limited (Formerly known as Kotak Mahindra General Insurance Company Limited) CIN: U66000MH2014PLC260291. IRDAI Reg. No. 152. Registered & Corporate Office: 401, 4th Floor, Silver Metropolis, Jai Coach Compound, Off Western Express Highway, Goregaon (East), Mumbai- 400063. Maharashtra, India.

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

4. Multiple Policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

5. Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
c) any other act fitted to deceive; and
d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

6. Cancellation

a. The Policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing. The Insurer shall -
   - For 1 year Policy-
     Refund proportionate premium for unexpired policy period subject to no claim(s) were made during the policy period.

   - For Multi Year Policy -
     - For any policy year where the risk date has not yet started, the premium will be refunded without any deduction.
     - For any policy year where the risk has started, the premium will be refunded on a pro-rata basis for that policy year, provided no claim has been made during the policy year and in full for future policy years.

   Additional Deductions: Notwithstanding the above, if (i) the risk under the Policy has already commenced, or (ii) only a part of the insurance coverage has commenced, and the option of Policy cancellation is exercised by the Policyholder, then expenses incurred by the Company on medical examination of the Policyholder will also be deducted before refunding of premium.

b. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

7. Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

8. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

Zurich Kotak General Insurance Company (India) Limited (Formerly known as Kotak Mahindra General Insurance Company Limited)
CIN: U66000MH2014PLC260291. IRDAI Reg. No. 152. Registered & Corporate Office: 401, 4th Floor, Silver Metropolis, Jai Coach Compound, Off Western Express Highway, Goregaon (East), Mumbai- 400063. Maharashtra, India.

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

9. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of atleast 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

v. No loading shall apply on renewals based on individual claims experience.

10. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

11. Premium Payment in Instalments

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. Grace Period of 15 days (where premium is paid on monthly instalments) and 30 days (where premium paid in quarterly / half yearly/ annual instalments) would be given to pay the instalment premium due for the policy.

ii. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also

iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.

Zurich Kotak General Insurance Company (India) Limited (Formerly known as Kotak Mahindra General Insurance Company Limited) CIN: U66000MH2014PLC260291. IRDAI Reg. No. 152. Registered & Corporate Office: 401, 4th Floor, Silver Metropolis, Jai Coach Compound, Off Western Express Highway, Goregaon (East), Mumbai- 400063. Maharashtra, India.

iv. No interest will be charged If the instalment premium is not paid on due date.

v. In case of instalment premium due not received within the grace period, the policy will get cancelled.

vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

12. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

13. Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement(if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

14. Redressal of Grievance

In case of any grievance the insured person may contact the company through
Website: www.zurichkotak.com
Toll free: 18002664545
E-mail: care@kotak.com
Courier: Zurich Kotak General Insurance Company (India) Limited, 401, 4th Floor, Silver Metropolis, Jai Coach Compound, Off Western Express Highway, Goregaon (East), Mumbai- 400063. Maharashtra, India.

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance
If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at grievanceofficer@zurichkotak.com
For updated details of grievance officer, kindly refer the link:
https://www.zurichkotak.com/customer-support/grievance-redressal-process
For senior citizens, please contact the respective branch office of the Company or call at 18002664545 or may write an e- mail at seniorcitizen@zurichkotak.com

Zurich Kotak General Insurance Company (India) Limited (Formerly known as Kotak Mahindra General Insurance Company Limited) CIN: U66000MH2014PLC260291. IRDAI Reg. No. 152. Registered & Corporate Office: 401, 4th Floor, Silver Metropolis, Jai Coach Compound, Off Western Express Highway, Goregaon (East), Mumbai- 400063. Maharashtra, India.

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

The details of the Insurance Ombudsman is available at:
https://www.zurichkotak.com/customer-support/grievance-redressal-process
The updated details of Insurance Ombudsman offices are also available on the website of Council for Insurance Ombudsmen: www.cioins.co.in/ombudsman
The details of the Insurance Ombudsman is available at Annexure I

Grievance may also be lodged through the Bima Bharosa Portal – https://bimabharosa.irdai.gov.in

15. Claim Settlement (Provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of claim along with claim form (and necessary documents)

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

16. Eligibility

Minimum Entry Age	1 day
Maximum Entry Age	No Limit

Insured Person will include Self (Group member) and the following relationships of the Group member: Lawfully wedded spouse (more than one wife)/ Partner (including same sex partners) and Live-in Partner, children (biological/ adopted/others), parents (biological/ foster), siblings (biological/ step), mother in-law, father in-law, son in-law, daughter in-law, brother in-law, sister in-law.
For the purpose of this Policy, Partner shall be taken as declared at the time of Start of the Policy Period and no change in the same would be accepted during a Policy Period. However, an Insured Person may request for change at the time of Renewal of the cover.

Zurich Kotak General Insurance Company (India) Limited (Formerly known as Kotak Mahindra General Insurance Company Limited)
CIN: U66000MH2014PLC260291. IRDAI Reg. No. 152. Registered & Corporate Office: 401, 4th Floor, Silver Metropolis, Jai Coach Compound, Off Western Express Highway, Goregaon (East), Mumbai- 400063. Maharashtra, India.

17. Material Change

Material information to be disclosed to Us includes every matter that You are aware of that relates to questions in the Proposal Form and which is relevant to Us in order to accept the risk and the terms of acceptance of the risk.

18. No constructive Notice

Any knowledge or information of any circumstances or condition in Your connection in possession of any of Our personnel and not specifically informed to Us by You shall not be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

19. Terms and condition of the Policy

The terms and conditions contained herein and in the Policy Schedule/ Certificate of Insurance of the Policy shall be deemed to form part of the Policy and shall be read together as one document.

20. Cause of Action/ Currency for payments

No Claims shall be payable under this Policy unless the cause of action arises in India, unless otherwise specifically provided in Policy. All Claims shall be payable in India and shall be in Indian Rupees only.

21. Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed by both You and Us to be adjudicated or interpreted in accordance with Indian law and only competent Courts of India shall have the exclusive jurisdiction to try all or any matters arising hereunder. The matter shall be determined or adjudicated in accordance with the law and practice of such Court.

22. Role of Group Administrator/ Policyholder

(a) The Policy holder should provide the complete list of members to Us at the time of policy issuance and renewal. Further intimation should be provided to Us on the entry and exit of the members at periodic intervals. Insurance will cease once the member leaves the group except when it is agreed in advance to continue the benefit even if the member leaves the group.
(b) In case of employer-employee policies, the employer may issue confirmation of insurance protection to the individual employees with clear reference to the Group Insurance policy and the benefits secured thereby.
(c) In case of such policies, claims of the individual employees may be processed through the employer
(d) In case of non-employer-employee policies, We shall generally issue the Certificate of Insurance. However, We may provide the facility to the Group Administrator to issue the Certificate of Insurance to the members.
(e) In case of such policies, the Group Administrator may facilitate the claims process for the members however the payment will be made only to the beneficiary which is the Insured Person

Zurich Kotak General Insurance Company (India) Limited (Formerly known as Kotak Mahindra General Insurance Company Limited) CIN: U66000MH2014PLC260291. IRDAI Reg. No. 152. Registered & Corporate Office: 401, 4th Floor, Silver Metropolis, Jai Coach Compound, Off Western Express Highway, Goregaon (East), Mumbai- 400063. Maharashtra, India.

23. Special Provision for Insured Person who are Senior citizen

The premium charged for health Insurance products offered to Senior citizens shall be fair, justified, transparent and duly disclosed upfront. The insured shall be informed in writing of any underwriting loading charged over and above the premium and the specific consent of the policyholder for such loadings shall be obtained before issuance of policy.

24. Communications & Notices

Any communication, notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to:

In Your case, at Your last known address per Our records in respect of this Policy.
In Our case, at Our address specified in the Policy Schedule/ Certificate of Insurance.
No insurance agent, broker or any other person is authorised to receive any notice on Our behalf.

25. Customer Service

If at any time You require any clarification or assistance, You may contact Our offices at the address specified in the Policy Schedule/ Certificate of Insurance, during normal business hours or contact Our call centre.

26. Electronic Transactions

You agree to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, teleservice operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the Policy or its terms, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time.

Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Insured. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated/confirmed by the Insured.

27. Assignment Clause

An assignment of this policy of insurance, wholly or in part, whether with or without consideration, may be made only by an endorsement upon the policy itself or by a separate instrument, signed in either case by the assignor and attested by at least one witness, specifically setting forth the fact of transfer or assignment and the reasons thereof, the antecedents of the assignee and the terms on which the assignment is made. Such assignment shall be operative as against the Company effective from the date the Company receives a written notice of the assignment/request and endorses the same on the Policy.
The Company may, accept the assignment, or decline to act upon any endorsement, where it has sufficient reason to believe that such transfer or assignment is not bona fide or is not in the interest of the policyholder or in public interest or is for the purpose of trading of insurance policy. However, by recording the

Zurich Kotak General Insurance Company (India) Limited (Formerly known as Kotak Mahindra General Insurance Company Limited) CIN: U66000MH2014PLC260291. IRDAI Reg. No. 152. Registered & Corporate Office: 401, 4th Floor, Silver Metropolis, Jai Coach Compound, Off Western Express Highway, Goregaon (East), Mumbai- 400063. Maharashtra, India.

assignment the Company does not express any opinion upon the validity nor accepts any responsibility on the assignment.

28. Automatic change in Coverage under the policy

The coverage for the Insured Person(s) shall automatically terminate in the case of any Insured Person's demise during the policy period/year:
Termination of cover takes place on account of death of the insured person and pro-rata refund of premium of deceased insured person is processed for the unexpired policy period, provided no claim has been made. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application.

29. Sanction Exclusion Clause:

Notwithstanding any other terms under this agreement, no insurer shall be deemed to provide coverage or will make any payments or provide any service or benefit to any insured or other party to the extent that such cover, payment, service, benefit and/or any business or activity of the insured would violate any applicable trade or economic sanctions law or regulation.

Details of Insurance Ombudsman

Office Details	Jurisdiction of Office Union Territory, District
Ahmedabad: Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
Bengaluru: Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
Bhopal: Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh and Chattisgarh.

Bhubneshwar: Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
Chandigarh: Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
Chennai: Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
Delhi: Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
Guwahati: Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
Hyderabad: Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
Jaipur: Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
Ernakulam: Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015.Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.

Kolkata: Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
Lucknow: Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
Mumbai: Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
Noida: Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
Patna: Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar and Jharkhand.
Pune: Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).